

Admission Form

Please complete and return this form to Rodney Surgical Centre, PO Box 317, Warkworth at least one week prior to your admission. You will be contacted on the day before your surgery and advised of your admission and fasting times.

Personal Information

	Surname		First Name(s)	
Mr/Mrs/Ms/Miss/Master	<input type="text"/>			
Preferred Name	<input type="text"/>	Date of Birth	<input type="text"/>	Age <input type="text"/> M <input type="checkbox"/> F <input type="checkbox"/>
Home Address	<input type="text"/>			
Postal Address	<input type="text"/>			
E-mail	<input type="text"/>			
Telephone Home	<input type="text"/>	Business	<input type="text"/>	Mobile <input type="text"/>
Occupation	<input type="text"/>	Ethnicity (optional)	<input type="text"/>	
Emergency Contact Name	<input type="text"/>	Relationship	<input type="text"/>	Telephone <input type="text"/>
Family Doctor	<input type="text"/>			Telephone <input type="text"/>

Payment Details

How will your procedure be paid for? *Tick and complete any sections required*

<input type="checkbox"/> Health Insurance	
Name of Insurer <input type="text"/>	Membership Number <input type="text"/>
Have you obtained "prior approval" for payment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Approval Number <input type="text"/>
<input type="checkbox"/> ACC (Personal expenses such as telephone calls are excluded)	Approval Number <input type="text"/>
<input type="checkbox"/> Paid Personally	<input type="checkbox"/> Other (please define) <input type="text"/>

Agreement

- I understand that any costs given to me before surgery are **estimates** only and that I am responsible for any outstanding balance if my procedure is not fully covered by insurance, ACC or another contract. I accept that in the event that my hospital account is not paid, Rodney Surgical Centre reserves the right to add all costs of collection to this account.
- I understand that the surgeon, anaesthetist and any other doctor or health professional using Rodney Surgical Centre's facilities for operations, consultations or otherwise in relation to my care and treatment, and in relation to my account payment, are independent contractors and are not employees, agents or members of Rodney Surgical Centre. Accordingly, I accept that Rodney Surgical Centre is not liable for their actions or omissions.
- I understand that from time to time, other clinical personnel may be required to be in the theatre during my procedure.
- I give permission to Rodney Surgical Centre to collect and store information and clinical photos about me and my treatment with the understanding that any information will only be used for its intended purposes; that it will be kept securely in my medical file and/or computer system; shared only with health professionals involved in my care; government bodies will only be provided with information to which they are legally entitled. I have the right to check the accuracy of any information and to request corrections if necessary.

Patient/Guardian Signature: Date:

If not patient, state relationship:

Patient Label

Health questionnaire

It is important that you answer all questions as accurately as possible. All information is sought to minimise your risk and will be retained as part of your confidential clinical records. We are happy to help you complete this form if you so require.

Please list previous hospital admissions including date and hospital (if known).

Reason for admission	Date	Hospital

Have you ever had or do you currently have any of the following? (Please tick Yes or No and **circle a word** where appropriate.)

<p>Diabetes: diet controlled/medication Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Diabetes: requiring insulin Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>High blood pressure/ palpitations Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Angina/heart attack/heart failure/chest pain Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Stroke/TIA Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Epilepsy/severe headaches Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Blackouts/fainting Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Asthma/wheeziness Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Emphysema/bronchitis/croup Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Persistent cough Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Obstructive sleep apnoea Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Rheumatic fever/heart murmur Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Tuberculosis Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Heart burn/acid reflux/hiatus hernia Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Indigestion/stomach or peptic ulcer Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Blood clots in legs/ lung Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Bleeding problems/anaemia/bruising Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Family history of bleeding problems Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Glaucoma Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Arthritis Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Thyroid disease Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Kidney disease Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Hepatitis A/B/C Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are you a hepatitis carrier Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>HIV/AIDS/risk of exposure to HIV Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>MRSA Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Have you had a "head cold", throat/chest infection or bronchitis in the past 4 weeks? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Boils, skin or other infections/septicaemia? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="padding-left: 20px;"><i>If yes, please specify.</i> <input style="width: 150px;" type="text"/></p> <p>Substance dependency/high use Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you smoke/used to smoke? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="padding-left: 20px;"><i>If yes, how many per day?</i> <input style="width: 100px;" type="text"/></p> <p>Do you drink alcohol daily? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="padding-left: 20px;"><i>If yes, how much?</i> <input style="width: 100px;" type="text"/></p> <p>Do you have any of the following: (please circle)</p> <p>dentures/partial plate/ capped/ loose teeth/contact lenses/ glasses/hearing aid/joint implants/pacemaker/heart valve/ other prosthetics/ implants/piercings</p> <p>Do you believe you are pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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If yes, which joints?

If yes, how many months?

Any other diseases or conditions? *If yes, please specify.*

Patient Label

Allergies

Allergies: please list any reaction/allergy you have had, e.g. to medications, tablets, plasters, food, latex/rubber or other substances.

What medications (including herbal or contraceptive) are you (the patient) taking?

Medication *Dose* *Frequency*

Do you suffer from motion sickness? *Mild/moderate/severe* Yes No

Do you have difficulty climbing more than one flight stairs? *If yes, what restricts this activity?* Yes No

Have you had an anaesthetic before? Yes No

Have you or a family member had any problems with an anaesthetic before? *If yes, please outline.* Yes No

Do you have problems opening your mouth or have you had previous jaw problems? Yes No

Have you been told of previous problems with your airway under anaesthesia? Yes No

Do you have any concerns or questions about your anaesthetic? *If so, please outline.* Yes No

IN PREPARATION FOR ADMISSION - add detail where necessary Your weight Your height

Do you wish to retain body parts/metalware? (A fee will apply for return of metalware) Yes No

Do you have a disability? Yes No

Physical support or aids? Yes No

Religious or spiritual needs? Yes No

Cultural or family/whanau needs? Yes No

Dietary requirements Yes No

Do you require RSC to organise someone to stay with you overnight (fee applies) Yes No Interpreter required Yes No

The details above have been completed by: (Please tick and sign below)
 Patient Guardian Relative Other (please specify) _____

If there are any changes to the above information before my admission, I will notify Rodney Surgical Centre immediately.

Signed: _____ Date: _____

Patient Label

Informed consent/Request for treatment (to be completed with Surgeon)

Date of procedure Time of appointment

Patient/Guardian

I agree that I have received a reasonable explanation of intent, risks, alternative treatment options, likely outcome and associated costs of the following operation/treatment:

to be carried out on myself/relative by Dr/Mr

(Please circle one) (Name of patient if patient not signing)

Specific risks are:

In the event of a hospital staff member being accidentally contaminated by my blood or body fluids, I consent to a sample of my blood being taken for Hepatitis B and H.I.V. (Aids) screening. I shall be informed of the results and counselled in their significance.

I have had explained and understood the risks and benefits of the use of blood and blood products and have had the opportunity to discuss their use. I AGREE to receiving these products if required.

Patient/Guardian signature: If not patient, state relationship:

Surgeon's signature: Date:

Anaesthetic Assessment and Consent (to be completed with Anaesthetist)

ASA - I, II, III, IV PONV Yes No GI reflux Yes No

Previous anaesthesia

Family history of GA problems

Past medical history

Airway

CVS

RS

Dentition

Lab results

Summary of general status

I understand that I require an anaesthetic for the above procedure. I understand that having an anaesthetic involves risks, and are in addition to the risks of the operation and procedure that I am having. I have had the opportunity to ask questions and have received all the information I want regarding its nature and effects. I give my informed consent to receiving an anaesthetic. I acknowledge not to drive a motor vehicle following my anaesthetic. I understand that I may receive Section 29 medications about which I will receive information post-operatively.

Patient signature:

Anaesthetist name: Anaesthetist signature:

Date: Proposed anaesthetic: GA MAC/S MAC SEDATION